Physicians Who Have Practiced in Both the United States and Canada Compare the Systems

ABSTRACT

Objectives. The aim of this study was to examine the US and Canadian systems from the unique perspective of physicians who have practiced in both Canada and the United States.

Methods. Questionnaires were sent to 355 Canadian physicians who graduated from US medical schools and 347 US physicians who graduated from Canadian medical schools.

Results. The overall response rate was 59% (65% of US-graduated Canadian physicians and 54% of Canadian-graduated US physicians). Thirty-six percent of the respondents were "dual experience" physicians; that is, they had practiced medicine in both countries after completing their medical training. Physicians who left Canada were more likely than those who left the United States to indicate dissatisfaction with the health care system as a reason for leaving. Respondents expressed greater professional satisfaction with their current country of practice, but overall, dual-experience physicians in the United States favored that system only slightly more than the Canadian system, whereas those in Canada rated the Canadian system significantly better than the US system.

Conclusions. The comparatively weak rating of the US system by dual-experience physicians underlines the need for health care reform. (*Am J Public Health.* 1993; 83:1544–1548)

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Introduction

In the United States, interest in the Canadian health care system is widespread.[1–3] A large percentage of the US public favors extensive health care reform.[4] Proposals for reform have sometimes drawn heavily on the Canadian model,[5] although this model has been viewed with skepticism by others.[6–8] Such skepticism has been fueled by signs of increasing stress within the Canadian system in recent years. Rising costs, efforts at cost control in the face of increasing benefits, and stagnant or depressed earnings among physicians have placed the Canadian health care system in jeopardy.[9–12]

Analytical comparisons between the US and Canadian health care systems can sometimes exclude the human side of the equation.[13–14] Given the close proximity of Canada to the United States, a sizable number of health professionals have had direct experience as providers in both systems. These physicians have a unique perspective that should be of particular interest to those seeking insights into methods of health care delivery. Yet the literature on the subject to date has been limited.[15–17] The current study takes this inquiry a step further.

Methods

Using the 1987 Canadian Medical Directory, we identified all Canadian physicians (488) who had graduated from US medical schools. The use of an older directory allowed for a minimum number of years of professional experience in Canada. A similar-sized group (533) of graduates of Canadian medical schools now practicing in the United States was gathered by identifying the first Canadian medical school graduate on every fifth page of the 1988 American Medical Association Directory. (There are about 17 times more Canadian-graduated US physicians than US-graduated Canadian physicians; each group represents roughly 1% of its respective work force.) Addresses for both groups were then updated, using the 1990 directories for both countries. We sought to identify physicians who had had direct professional experience in both the United States and Canada, without a requirement as to original country of residence. The respondents thus included individuals with a variety of backgrounds and included both Canadian and US citizens who attended medical school outside their own country, some of whom stayed on to receive further medical training or to practice medicine before returning to their own country.

Questionnaires were mailed to 813 physicians so identified for whom current addresses were available. Questionnaires proved deliverable to 702 physicians (355 Canadian and 347 US) and 414 were returned, 232 (65%) from Canadian physicians and 182 (54%) from US physicians (overall response rate, 59%).

Results

Of the 414 respondents, 256 (62%) obtained additional professional training (internships, residencies, and/or fellowships) in the same country as their medical school. Further, 147 respondents (36%)

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practiced medicine in both countries after medical training, averaging 10.43 years of experience in the Canadian system and 10.98 years in the US system. We will refer to this group as "dual experience" physicians.

Men made up 76% of the sample and women 20% (4% did not report their sex). The respondents were predominantly (88%) White. Five percent were Black, Asian, or Hispanic (7% did not report their race/ethnicity). Age was reported in 10-year increments. The predominant age group was 40 through 49 years of age, especially in the Canadian sample, where 49% of all respondents fell into this age group.

Respondents were divided into two groups. "Primary care providers" included those practicing in nonsurgical areas of medicine that traditionally provide primary care services the majority of the time: general practice, family practice, pediatrics, and internal medicine (including geriatric medicine). All others were classified as "non–primary care specialists." The sample consisted of 166 (40%) primary care physicians and 234 (57%) non–primary care specialists (3% did not report their field of practice).

The questionnaire focused on global measures of satisfaction with the respondents' professional experience in each country. Respondents were asked: Overall, how would you rate your level of satisfaction with your experience as a practicing physician? As a practicing physician, how satisfied are you with the financial compensation for your work? As a practicing physician, how satisfied are you with the quality of medicine you have been able to practice? Separate answers were given for each system. Additional questions addressed the impact of cost containment measures and asked each physician to compare the two systems directly, using a single overall rating. For dual-experience physicians, an additional question asked for the reasons they had left their first country of practice. Respondents were invited to expand on their responses with additional narrative.

The 147 dual-experience physicians were of greatest interest; except where noted, all results were drawn from this group, which consisted of 75 Canadian physicians and 72 US physicians. Table 1 summarizes the reasons members of this group left their first country of practice; Table 2 compares the answers of the Canadian and US dual-experience physicians to the global satisfaction questions.

TABLE 1—Percentages of Dual-Experience Physicians Giving Reasons for Leaving Previous Country of Practice

Reason	Physicians Who Left the United States (n = 75)	Physicians Who Left Canada (n = 72)
Generally dissatisfied with system	25	43*
Unable to practice quality of medicine desired	13	29*
Unhappy with financial rewards	5	47**
Personal reason(s) unrelated to problems with the health care system		
In addition to one or more of above	32	28
Personal reason(s) only	48*	39

Note. Except for those who cited personal reasons only, respondents could select more than one reason.
*$P < .05$ (chi-square test); **$P < .001$ (chi-square test).

TABLE 2—Satisfaction of Dual-Experience Physicians with Canadian and US Health Care Systems

	Primary Care Physicians		Non–Primary Care Specialists		Total Sample	
	Canada (n = 37)	United States (n = 33)	Canada (n = 38)	United States (n = 39)	Canadian Physicians (n = 75)	US Physicians (n = 72)
Level of Satisfaction	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Overall, Canada	5.1 (1.4)**	4.0 (2.1)	5.5 (1.0)*	3.9 (1.9)	5.3 (1.3)*	4.0 (2.0)
Overall, United States	3.4 (1.5)	4.9 (1.5)*	4.3 (1.6)	5.1 (1.4)**	3.9 (1.6)	5.0 (1.5)*
With financial compensation, Canada	4.6 (1.7)*	3.3 (1.8)	4.5 (1.6)*	3.4 (1.7)	4.6 (1.6)*	3.4 (1.8)
With financial compensation, United States	4.7 (1.6)	5.4 (1.5)	5.0 (1.0)	5.6 (1.3)**	4.8 (1.3)	5.5 (1.3)*
With quality of medicine able to practice in Canada	5.4 (1.4)**	4.5 (2.0)	5.9 (1.0)*	4.1 (1.8)	5.6 (1.3)*	4.3 (1.9)
With quality of medicine able to practice in United States	4.3 (1.6)	5.3 (1.5)**	4.8 (1.7)	5.9 (0.9)*	4.6 (1.7)	5.6 (1.2)*

*Note. Responses were made on a 7-point scale: 1 = completely dissatisfied, 4 = opinion neutral, 7 = completely satisfied.
*$P < .01$ (unpaired t test); **$P < .05$ (unpaired t test).

Physicians who had left Canada were significantly more likely than their US counterparts to express dissatisfaction with the health care system as a reason for leaving ($P < .05$; financial compensation, $P < .001$). Nearly half (48%) of those who had left the United States did so for strictly personal reasons unrelated to their experience with the US health care system (most commonly employment opportunities).

Physicians' expressions of satisfaction with their professional experience in their current country were significantly better than ratings of that country by physicians who had left ($P < .05$), with the exception of Canadian physicians' expressions of satisfaction with the financial rewards of both systems, which were essentially equal. Further dividing the Table 2 sample into those expressing dissatisfaction with the health care system and those giving only personal reasons (unrelated to the health care system) for switching countries showed that those with strictly personal reasons rated their initial country more highly than those expressing dissatisfaction.

Specialists in both countries indicated levels of satisfaction equal to or

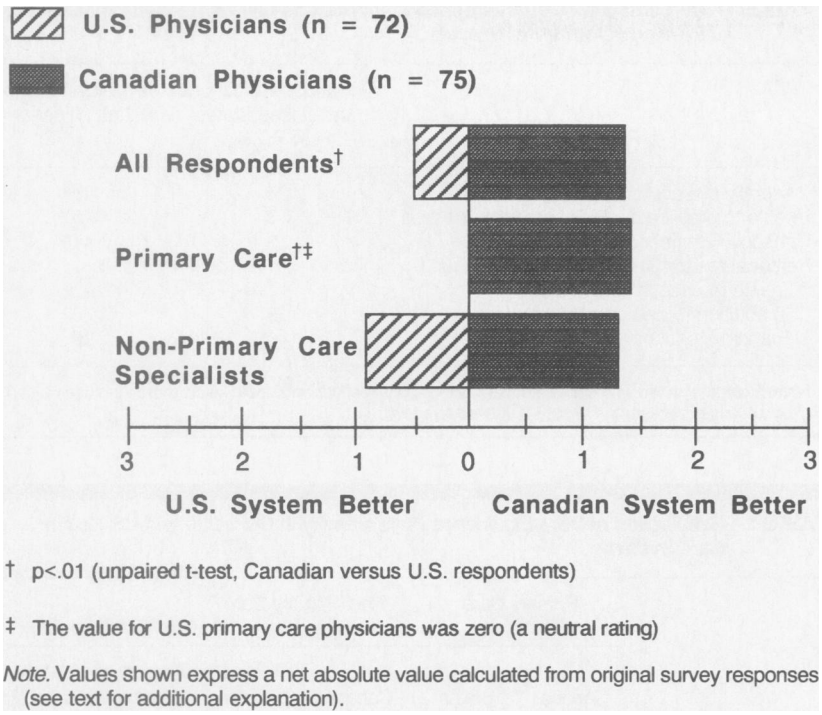

FIGURE 1—Strength of support for current system among physicians with experience in both the United States and Canada.

higher than those of primary care physicians. US physicians, both primary care physicians and specialists, were more satisfied with their earning ability in the United States than with their previous earning ability in Canada. Canadian specialists were more satisfied with levels of compensation in the United States than in Canada, but to a lesser degree than their US counterparts, whereas Canadian primary care physicians expressed essentially equal satisfaction with their income in both countries.

Regarding the effect of cost containment measures on their ability to practice, both Canadian and US physicians indicated only a slight to moderately negative impact. There was no statistically significant difference between the two groups, except that Canadian specialists viewed US efforts at cost containment more negatively than did US specialists ($P < .05$).

Juxtaposed against the preceding data, the answers to the question "How would you rate the Canadian and US health systems in comparison to each other?" were unexpected. Each group again favored its current country, with the exception that US physicians who had left Canada for strictly personal reasons rated the Canadian system slightly better. The strength of response, however, was significantly different. For this question, responses given on a 7-point scale (1 = US system better, 7 = Canadian system better) were subtracted from the question's neutral rating of 4. The absolute net value of this calculation is seen in Figure 1, which demonstrates, in an overall sense, the strength of dual-experience physicians' rating of their current country over their previous one: Canadian physicians' rating of their own system was three times greater in strength than US physicians' rating of the US system ($P < .01$). Among all respondents, the Canadian physicians' rating of their current system was more than four times greater in strength than the US physicians' rating of the US system ($P < .01$).

It is useful to further divide the dual-experience group based on the time period in which practice experience occurred: those who, at least in part, practiced in both countries between 1970 and 1980 (n = 112) and those whose practice experience in both countries included years after 1980 (n = 99). The first group had the opportunity to experience the US Medicare and Medicaid programs begun in the mid-1960s as well as Canada's shift to its provincially based system, which was complete by 1972. (Most governmental programs for hospital coverage in Canada began in the late 1950s and were in place by the mid-1960s in all provinces; most governmental outpatient programs began in the mid-1960s and were in place in all provinces by 1972.) The second group had the chance to experience the more recent strains on the Canadian system as well as the institution of diagnosis-related groups in the United States.

When results from these subgroups were compared with those of the entire dual-experience group, only two important differences were seen. Among US physicians who left Canada sometime after 1970, mean values for overall satisfaction with the Canadian system as well as for quality of care and financial compensation in that system were somewhat lower than values in the entire group of US dual-experience physicians. In the subgroup of US physicians who had left Canada after 1980, a similar drop in mean values was seen regarding the level of compensation in Canada. All other fluctuations in mean values were minimal. Overall, the differences shown in Figure 1 were not substantially altered when we focused on physicians with more up-to-date experience in both systems.

Comment

As an important information source, physicians who have had direct professional experience in both Canada and the United States have been underutilized. These individuals have been "in the trenches" on both sides of the border and have seen how each system works on a day-to-day basis. Their input is a valuable addition to more theoretical analyses. In identifying every US-graduated Canadian physician and a similar-sized sample of Canadian-graduated US physicians, we sought to harness the real-life perspective of these unique groups.

These groups may not be representative of all Canadian or US physicians. In addition, the respondents were self-selected and may not be the same as nonrespondents. An analysis of respondents to the first and second mailings provides some information on this issue, since initial nonrespondents became part of the second group of respondents. We used simple t tests to compare all measures for these two groups. Only one of 16 comparisons was significant; this was approximately the number of differences expected on the basis of chance alone at $P = .05$. Respondents to the first mailing rated the US system significantly more highly than did second-mailing respondents. If such a difference is real, subsequent mailings to nonrespondents would

only be expected to strengthen the results we obtained. Thus there is little reason, based on the data themselves, to suspect that if more opinions from nonrespondents were included, different conclusions would be reached.

The evolution of Canada's single-payer system was associated with protests from physician groups who feared governmental involvement. Those less enamored of the radical changes occurring in Canadian health care may have been more likely to leave when the opportunity arose. Thus, on the one hand, we expected the results summarized in Table 1: physicians who chose to leave Canada more commonly expressed dissatisfaction with the system as a reason for leaving than did their counterparts who left the United States. Yet levels of satisfaction with their current country were essentially equal: Canadian physicians were generally as satisfied with their professional experience as were US physicians, and they were reasonably satisfied with their financial rewards (Table 2). Further, notwithstanding the knowledge that their income would be greater in the United States, Canadian specialists in our sample expressed relative contentment with their practices as measured by levels of overall satisfaction and satisfaction with the quality of medicine they are able to practice. In both cases these indicators were equivalent to those of US specialists.

The most unexpected result was the relatively weak rating of the US system by US dual-experience physicians (Figure 1). We had expected a stronger rating of the US system by these US physicians as compared with the rating of the Canadian system by Canadian physicians, both because dissatisfaction with the health care system was more commonly expressed by physicians leaving Canada for the United States and because financial remuneration in the United States is greater. In this survey, the opposite proved the case. This result is not clearly explained by the global measures of satisfaction previously described, but it is partly accounted for by the fact that among physicians who moved from one country to the other for strictly personal reasons, current US physicians rated Canada slightly better while Canadian physicians strongly favored Canada. Although both US and Canadian physicians were reasonably and equally satisfied with their current practices, a compilation of solicited comments from the current survey offers some potential clues to explain the results summarized in Figure 1.

Three issues were most often raised in the respondents' comments: access to care, administrative responsibilities, and medical malpractice. These issues were consistent with previously acknowledged strong points within the Canadian system.[2,3] The need for better access to care in the United States, a widely discussed issue in the current literature,[18,19] was by far the most common concern expressed. It appeared that once physicians had experienced the positive effects of universal access (in Canada), it was difficult to accept their absence (in the United States). Universal access was seen as a major benefit not only to the patient but to the practitioner, who no longer needed to worry about the patient's ability to pay in determining a course of action.

The inefficient paperwork jungle common to US health care[20,21] was contrasted with the simplified administrative tasks of the Canadian system. Although the comments indicated that administrative requirements were increasing in Canada, Canada's provincially run, single-payer system remained extraordinarily simple compared with the US system. Although respondents were often concerned with the administrative overload in the United States, there was essentially no call for a single-payer system. Rather, the overall sentiment was in favor of maintaining a public-private insurance structure but with sufficient changes to decrease the administrative burden.

Medical malpractice was seen as a serious issue in both countries. The number of lawsuits has increased in both Canada and the United States. Canadian physicians expressed concern with the trend. Yet for dual-experience physicians the problems with medical malpractice in Canada paled in comparison with those in the United States. Even today, "Canadian physicians are only one fifth as likely to be sued for malpractice as their American counterparts."[22]

Nevertheless, it should be emphasized that physicians who left Canada were clearly more satisfied with their practices in the United States than in Canada. Their responses should not be construed as a call for the "Canadianization" of the US health care system. Rather, the message was that the United States should seek to learn from the successes of others. Instead of being the experimenter, the US system can take what has worked elsewhere and combine it with its own many strengths. Examples of how this might be done may come from Canada, from other countries,[23–25] or from within our own country.[26,27]

The weak rating of the US system by US dual-experience physicians can reasonably be interpreted as a call for a more careful analysis and probable reform of at least certain aspects of the US system, including issues of access, administrative burdens, and malpractice costs. The data gathered in this study, especially considering the generally conservative nature of physicians as a group, emphasize the need for change in the way health care is provided in the United States. □

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